| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | | A. BUILDING 00<br>B. WING | 06/30/2011 |

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| MILLER BEACH TERRACE | 4905 MELTON ROAD<br>GARY, IN46403 |

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| R0000 | This visit was for the State Residential Licensure Survey.<br><br>Survey Dates: June 29 & 30, 2011<br><br>Facility Number: 001140<br>Provider Number: 001140<br>AIM Number: N/A<br><br>Survey Team:<br>Heather Tuttle, R.N. T.C.<br>Lara Richards, R.N.<br>Kathleen Vargas, R.N.<br>June 29, 2011<br><br>Census Bed Type:<br>106 Residential<br>106 Total<br><br>Census Payor Type:<br>106 Other<br>106 Total<br><br>Sample: 7<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed 7/5/11<br>Cathy Emswiller RN | R0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| R0036 | (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) a need to alter treatment significantly, that is, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.<br>Based on record review and interviews, the facility failed to ensure the resident's physician was promptly notified of a significant change in the resident's status related to a black and blue eye that was swollen shut for 1 of 7 resident's reviewed for physician's orders. (Resident #2)<br><br>Findings include:<br><br>The record for Resident #2 was reviewed on 6/28/11 at 10:50 a.m. Review of Nursing Progress Notes dated 5/19/11 (no time) indicated the resident's right upper and lower eye was purple and his eye was closed shut. The resident sustained it from a physical altercation with his roommate on 5/18/11. The resident refused to go to the hospital at 8:00 a.m. when the nurse attempted to send him. There was no documentation indicating the resident's physician was notified on | R0036 | A chart audit was completed to ensure that no similar items had occurred.A Physician notification form has been developed to document that physician had been notified of any change in condition. Nurses have been in-serviced on the use of Physician Notification forms.Nursing staff responsible.DON to monitor forms weekly, ongoing. | 07/20/2011 |

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| | 5/18/11 when the incident and injury had happened.<br><br>The next documented entry in Nursing Progress Notes was on 5/19/11 at 12:20 p.m., which indicated the resident was being transferred to the hospital for an X-ray and further assessment of his right eye. The resident's physician was made aware of the his transfer and black eye at that time.<br><br>Interview with the Director of Nursing on 6/29/11 at 12:45 p.m., indicated the resident's physician should have been notified earlier of the right eye bruised and swollen shut. | | | |

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| R0045 | (6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following:<br>(A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following:<br>(i) The resident.<br>(ii) A family member of the resident if known.<br>(iii) The resident ' s legal representative if known.<br>(iv) The local long term care ombudsman program (for involuntary relocations or discharges only).<br>(v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility.<br>(vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions.<br>(vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F).<br>(B) Record the reasons in the resident ' s clinical record.<br>(C) Include in the notice the items described in subdivision (9).<br>(7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged.<br>(8) Notice may be made as soon as practicable before transfer or discharge when:<br>(A) the safety of individuals in the facility would be endangered;<br>(B) the health of individuals in the facility | | | |

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| | would be endangered;<br>(C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge;<br>(D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or<br>(E) a resident has not resided in the facility for thirty (30) days.<br>(9) For health facilities, the written notice specified in subdivision (7) must include the following:<br>(A) The reason for transfer or discharge.<br>(B) The effective date of transfer or discharge.<br>(C) The location to which the resident is transferred or discharged.<br>(D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " .<br>(E) The name of the director and the address, telephone number, and hours of operation of the division.<br>(F) A hearing request form prescribed by the department.<br>(G) The name, address, and telephone | | | |

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| | number of the state and local long term care ombudsman.<br>(H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission.<br>Based on record review and interview, the facility failed to ensure a resident who was discharged from the facility received documentation in writing regarding his discharge for continuity of care for 1 of 2 closed records reviewed. (Resident #3)<br><br>Findings include:<br><br>The record for Resident #3 was reviewed on 6/28/11 at 12:30 p.m. The resident was admitted to the facility on 4/4/11. The resident was admitted to the hospital on 4/15/11 for a circumcision and lithotripsy. The resident returned to the facility on 4/18/11. On 4/19/11 the resident was sent back to the hospital for penile edema and uncontrollable bleeding. The resident returned to the facility on 4/19/11. Nursing Progress Notes dated 4/22/11 indicated the resident's penile edema was resolved but the area was still painful to touch. The last documented entry in Nurse's Notes was on 4/28/11 and there was no information regarding the resident's discharge from the facility.<br><br>Review of Physician orders dated April | R0045 | A chart audit was completed to ensure that no similar items had occurred.A Discharge Instruction Form has been developed and nursing has been in-serviced on its use.Nursing staff responsible.DON to monitor weekly by reviewing discharged charts, on-going. | 07/20/2011 |

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| | 4th, 2011, indicated there was no order for the resident to be discharged. There was no documentation of any discharge planning for the resident when he returned to the community. There were two physician order sheets dated may 2, 2011, with the resident's medications on them. The resident had signed by everyone of his medications and the Director of Nursing also had signed by the medications.<br><br>Interview with the Director of Nursing on 6/28/11 at 3:00 p.m., indicated the resident's signature meant that he was discharged with those medications. The Director of Nursing indicated the resident was discharged to the community on 5/2/11, however, there was no information or discharge instructions given to the resident at the time of discharge. | | | |

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| R0120 | (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows:<br>(1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel.<br>(2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia.<br>(3) Inservice records shall be maintained and shall indicate the following:<br>(A) The time, date, and location.<br>(B) The name of the instructor.<br>(C) The title of the instructor.<br>(D) The names of the participants.<br>(E) The program content of inservice.<br>The employee will acknowledge attendance by written signature. | | | |
| | Based on record review and interview, the facility failed to ensure all new employees received six hours of dementia training within the first six months of employment | R0120 | Dementia training will be scheduled quarterly to ensure new employees have dementia training completed in a timely manner. Personnel supervisor | 07/18/2011 |

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| | for 3 of 4 newly hired employees. (Employee #1, #2, &, #3)<br><br>Findings include:<br><br>1. Review of the employee files on 6/29/11 at 10:00 a.m., indicated the required six hours of dementia training for the following employees was not competed within the first six months of hire.<br><br>Employee #1 was hired on 6/29/10.<br>Employee #2 was hired on 7/20/10.<br>Employee #3 was hired on 8/19/10.<br><br>Interview with the Business Office Manager on 6/29/11 at 1:15 p.m., indicated their six hours of training was not completed until 3/11/11 and not within the first six months of hire. | | responsible to schedule new employees for training. Office Manager to monitor files, visually, quarterly, to ensure compliance. | |
| R0144 | (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents.<br>Based on observation and interview, the facility failed to maintain an environment that was clean and in the state of good repair, related to torn chair cushions, dirty chairs, missing and non-functioning light bulbs, missing cove base, peeling paint, marred walls, stained and missing caulking, soiled windows, broken floor | R0144 | A, B, C, D, E, F, G, H, I, J, K, L, P, Q, R, CC, DD, EE, FF, GG, HH, II, JJ, LL In-depth rounds have been completed to identify similar items throughout the facility. Corrective action has been completed. The IMLR (Internal Maintenance Log Report) has been updated to include caulking, bathroom light | 07/20/2011 |

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| | tiles, stained tile grout, stained and damaged ceilings, missing light shields and torn and soiled carpeting on 2 of 2 units as well as the Great Room, the Television Room and the Dining Room. This deficient practice had the potential to affect 106 of 106 residents residing in the facility. (Dining Room, Television Room, Great Room, 100 Unit and 300 Unit)<br><br>Findings Include:<br><br>1. During the environmental tour on 6/29/11 at 10:00 a.m., with the Maintenance Supervisor, the following was observed:<br><br>A. The caulking around the bathroom sink was stained in the bathroom of room 310. There were 2 persons residing in room 310.<br><br>B. There was a 4 inch diameter hole in the ceiling of the bathroom in room 310. There was paper towel crumpled and placed in the hole. The ceiling area surrounding the hole was stained. Interview with the Maintenance Supervisor indicated there had been a water leak.<br><br>C. The grout on the bathroom floor of room 310 was soiled. | | shields, light shades, threshold carpeting, bathroom ceilings, bathroom light fixtures, cove base, bathroom floor tile, wall tile and door trim. Housekeeping staff have been in-serviced on the importance of using the IMLR correctly and daily. Maintenance staff responsible for corrective action using the IMLR. Maintenance supervisor to monitor, visually, one time weekly using IMLR, on-going. M, N, O, KK Ceiling of the shower in room 349 has been scraped, sanded, primed and painted. The mar on the wall has been repainted. The wall repair outside room 349 has been completed. The ceiling in room 111 was repainted. Housekeeping staff have been in-serviced on the importance of using the IMLR correctly and daily. Maintenance staff responsible for corrective action using the IMLR. Maintenance supervisor to monitor, visually, one time weekly using IMLR, on-going. S A new window has been ordered from Lazzarro and will be installed by contractor on 07/20/11. Housekeeping staff have been in-serviced on the importance of using the IMLR correctly and daily. Maintenance staff responsible for corrective action using the IMLR. Maintenance supervisor to monitor, visually, one time weekly using IMLR, on-going. T, U, V, W, X, Y Outside windows were cleaned in great room. Outside | |

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| | D. The bathtub in room 310 was soiled and in need of cleaning.<br><br>E. The bathroom light fixture in room 310 had 3 of 3 light shields missing.<br><br>F. There was a 6 inch by 1 inch piece of torn carpeting on the floor in room 310.<br><br>G. In the 300 hall, the cove base was pulling away from the wall between rooms 312 and 314.<br><br>H. The carpeting outside of room 324 had a 3 foot stained area. Interview with the Maintenance Supervisor indicated there had been a water leak.<br><br>I. The carpeting in the threshold of room 321 was torn.<br><br>J. There were 3 broken floor tiles in the bathroom of room 321. There was 1 person residing in room 321.<br><br>K. In room 321, 3 of 3 light shields were missing in the bathroom light fixture.<br><br>L. The bathroom light fixture in room 349 had 3 of 3 light shields missing. There was 1 person residing in room 349.<br><br>M. The paint on the ceiling of the shower in room 349 was peeling. | | windows have been put on maintenance schedule for quaterly/as needed cleaning. Carpet/threshold was cleaned/repaired in great room and TV room as needed. The couch with the broken leg was disposed of and the chandelier light bulbs have been replaced. Maintenance staff responsible for repairs. Maintenance supervisor to monitor, visually, weekly, on-going. Z, AA, BB The booth cushions were repaired. The 124 chairs in the dining room were power washed. The ceiling fans in the dining room were cleaned. Maintenance staff responsible. Dietary supervisor to monitor, visually, 5 times per week, on-going. | |

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| | N. There was a black mar on the wall of room 349 that was 2 inches wide and 6 feet in length.<br><br>O. The wall outside of the bathroom in room 349 had a 2 foot square area of rough plaster that need to be sanded and painted.<br><br>P. In room 332, 3 of 3 light shields were missing in the bathroom light fixture. There were 2 persons residing in room 332.<br><br>Q. The bath tub in room 332 was soiled and the caulking around the bath tub was stained yellow.<br><br>R. A 4 inch square wall tile in the bathroom of room 332 was loose from the wall.<br><br>S. The window in room 332 had a broken seal and was in need of repair.<br><br>T. The carpeting in the Great Room had 3 two foot areas that were soiled and in need of cleaning. Interview with the Maintenance Supervisor indicated the soiled areas were due to coffee spills.<br><br>U. All the windows in the Great Room were in need of cleaning. | | | |

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| | V. In the Great Room, 1 of 4 couches had a broken leg post.<br><br>W. There were 2 chandeliers in the Great Room. One chandelier had 5 of 12 lights missing or non-functioning. The other chandelier had 9 of 12 lights missing or non-functioning.<br><br>X. There was a 10 foot by 1 inch section of carpeting that was torn in the Television Room.<br><br>Y. There was a 3 inch piece of metal threshold that was bent and in need of repair in the Television Room.<br><br>Z. In the Dining Room, 5 of 23 booth cushion seats had tears and were in need of repair.<br><br>AA. 124 of 124 chairs in the Dining Room had dust and food debris on the metal frames. All the chairs were in need of cleaning.<br><br>BB. 4 of 4 ceiling fans in the Dining Room had an accumulation of dust and were in need of cleaning.<br><br>CC. On the 100 hall, there were 2 stained ceiling tiles between rooms 107 and 109. | | | |

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| | DD. The carpeting at the threshold of room 109 was torn. There was 1 person residing in room 109.<br><br>EE. There was no caulking around the sink in room 109.<br><br>FF. The floor behind the toilet in room 109 was soiled.<br><br>GG. The light in the shower of room 109 was not functioning.<br><br>HH. There was a 6 inch piece of missing cove base in the bathroom next to the shower in room 109.<br><br>II. In room 111, burn areas on 2 of 2 lamp shades were observed. There were 2 persons residing in room 111.<br><br>JJ. There was a 3 inch piece of missing cove base near the bottom of the door frame in room 111.<br><br>KK. The ceiling in room 111 was stained. Interview with the Maintenance Supervisor indicated there had been a water leak.<br><br>LL. There was a 2 foot section of door trim outside of room 112 that was missing. | | | |

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| | | A. BUILDING 00<br>B. WING | 06/30/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| MILLER BEACH TERRACE | 4905 MELTON ROAD<br>GARY, IN46403 |

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| | Interview with the Maintenance Supervisor at the time of the environmental tour, indicated all of the above areas were in need of cleaning and/or repair. | | | |
| R0154 | (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.<br>Based on observation and interview, the facility failed to ensure the Main Kitchen was clean and in good repair, related to a soiled microwave, soiled stove burners, a missing stove top grate, broken oven doors, soiled floors, soiled transportation carts, soiled dishwasher area, stained ceiling tiles, soiled fan blades, and a soiled can opener for 1 of 1 kitchens. (Main Kitchen)<br>Findings include:<br><br>1. During the full kitchen sanitation tour of the Main Kitchen on 6/29/11 at 9:00 a.m., with the Day Shift Cook, the following was observed:<br><br>A. The metal shelf in the dish room was soiled and in need of cleaning.<br><br>B. The door to the dishwasher was soiled and in need of cleaning. | R0154 | A, B, G, H, J, K, L, M, N A dietary staff member has been assigned to cleaning duties. A new internal dietary cleaning schedule and a new deep cleaning schedule (monthly) have been developed by the new dietary supervisor to include mentioned items on survey. Lead dietary aide responsible. Dietary supervisor to monitor, visually, 5 times weekly, on-going. C The gap in the dishroom has been repaired. Lead dietary aide responsible. Dietary supervisor to monitor, visually, 5 times weekly, on-going. D, E, F Items D, E and F were a result of a leak in the roof over the dietary area. 2 bids have been received for needed repairs and we are waiting for one more bid. A decision will be made and contract signed for repairs within 30 days. completion date: 08/22/11 + for job and repairs I The oven door handles have been ordered and will be replaced when they are received. Lead | 07/20/2011 |

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| | C. There was a gap between the floor and the wall in the dish room. The area was 1/2 wide and an accumulation of dirt and food debris was noted in the gap.<br><br>D. There was a light missing in the oven hood. Interview with the Day Shift Cook indicated water had leaked from the ceiling through the light fixture.<br><br>E. There was a stained ceiling tile near the oven hood.<br><br>F. In the dry storage area, the ceiling had a metal beam that was rusted. The ceiling area around the beam was stained. Interview with the Day Shift Cook indicated there was a water leak from the roof.<br><br>G. The blades of the fan had an accumulation of dust.<br><br>H. There were 7 containers of spices on the shelf below the food prep table. The containers had an accumulation of dirt and grease and were in need of being cleaned.<br><br>I. The oven had 2 of 4 door handles broken and were in need of being repaired.<br><br>J. The floor beneath the food prep table | | dietary aide responsible. Dietary supervisor to monitor, visually, 5 times weekly, on-going. | |

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| | had a large accumulation of dust and dirt.<br><br>K. The grout between the floor tiles throughout the kitchen was soiled with dirt and grease and in need of deep cleaning.<br><br>L. The can opener had an accumulation of dirt and food particles and was in need of cleaning.<br><br>M. The top of the stove had an accumulation of dirt and grease. 1 of 6 stove grates was missing.<br><br>N. The 2 transportation carts had an accumulation of dirt on the inside of the carts as well as on the outside of the carts. Both carts were in need of cleaning.<br><br>Interview with the Day Shift Cook at the time of the sanitation tour indicated all of the above areas were in need of cleaning and/or repair. | | | |
| R0155 | (l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items.<br>Based on observation and interview, the facility failed to ensure waste was properly secured in 1 of 2 dumpsters. | R0155 | Maintenance staff was in-serviced on the importance of keeping garbage cans | 07/15/2011 |

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| | Findings include:<br><br>During the environmental tour on 6/29/11 at 10:00 a.m., two dumpsters were observed outside of the facility. The lid to one of the dumpsters was raised up, exposing the waste contents.<br><br>Interview with the Maintenance Supervisor at that time, indicated the lids to the dumpsters were to be closed at all times. | | closed.Maintenance staff responsible. Maintenance supervisor to monitor, visually, three times daily, 5 times weekly, ongoing. | |
| R0241 | (e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows:<br>(1) Medication shall be administered by licensed nursing personnel or qualified medication aides.<br>Based on record review and interview, the facility failed to ensure the administration of medications and the provision of residential nursing care was completed as ordered related to monitoring of increased behaviors that required repeated hospital visits, discontinuing medications as ordered, monitoring for the effectiveness of as needed (prn) medications, monitoring blood pressure prior to giving | R0241 | A chart audit was completed to ensure that no similar items had occurred.1. A 15 minute check sheet has been developed and nursing has been in-serviced on its use. In-service was done with nursing on the documentation of PRN medications. An appointment sheet was developed from the ward clerk, who makes the appointments to the nursing staff. The nurses, when they see the resident, can | 07/20/2011 |

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| | blood pressure medications and the lack of notifying the physician of critical lab results which resulted in a hospitalization for 2 of 7 sampled residents. (Residents #1 and #5)<br><br>Findings include:<br><br>1. The record for Resident #5 was reviewed on 6/29/11 at 10:30 a.m. The resident's diagnoses included, but was not limited to, schizophrenia.<br><br>A change of condition Service Plan dated 3/23/11, indicated the resident wandered, had confusion and was disorganized and had a hygiene change due to confusion. The Service Plan indicated the resident had a change in his level of care and the facility was waiting on a bed at a long term care facility in another state.<br><br>The progress note completed by psychiatric services on 3/23/11, indicated the resident was seen as a crisis intervention due to the following concerns: Director of Nursing reporting bizarre behavior with the resident and change in overall mental status. Resident reports problems with sleeping. Resident rated his depression a "7" on a scale of 1-10. The resident also reported feeling angry and that if he did not get some help, he may hurt himself or someone else. | | check with the resident to see if any forms came back with them from the doctor. The nurses and ward clerk have been in-serviced on the use of the appointment sheets. Nursing staff responsible.DON will audit MAR's daily to ensure that blood pressures are taken and recorded as well as medications dispensed, on-going.2. Nursing was in-serviced on the importance of assessment and documentation on resident's with critical lab results. The DON has changed the nursing policy. Nursing staff with now contact and speak with the doctor on any critical lab notifications. Nursing staff responsible. DON to monitor daily, by reviewing lab sheets, on-going. | |

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| | An entry in the Nursing Progress notes dated 3/23/11 at 10:10 a.m., indicated the resident was being transferred to the Emergency Room for evaluation due to increased adverse behaviors, wandering, increased auditory hallucinations and verbal statements of feelings of harming himself and others. The resident returned from the hospital on 3/25/11. Documentation in the Nursing progress notes at 1:55 p.m., indicated the resident was to follow up with the facility therapist.<br><br>The next documented entry was on 3/28/11 at 12:25 p.m., three days later, indicating the resident was being sent to the Emergency Room for evaluation for increased confusion, inability to form sentences, decreased hygiene, increased wandering and increased auditory hallucinations. The next entry in the progress notes was on 3/29/11 at 10:30 a.m., there was no documentation to indicate when the resident returned from the hospital.<br><br>After the 3/29/11 at 10:30 a.m. entry, the next entry in the progress notes was dated 3/30/11 at 1:12 p.m., which indicated the resident was again transferred to the Emergency Room for evaluation for deterioration in mental status. The | | | |

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| | resident had wandered to his brother's house at 7:00 a.m. and was improperly dressed. The resident's physician was notified of the increased confusion, medication non-compliance, wandering and being non-responsive to simple directions.<br><br>The next entry in the progress notes after 3/30/11 was on 4/5/11 at 2:45 p.m. There was no documentation to indicate when the resident returned from the hospital. The resident was insisting he needed to leave the facility. The Director of Nursing was notified and half hour checks were initiated. There was no documentation available related to the resident's whereabouts every half hour.<br><br>On 4/6/11 at 12:45 p.m., the resident was again sent to the Emergency Room for psychiatric evaluation and assessment. The resident had increased auditory hallucinations with increased delusions and increased attempts to leave the facility. The resident was also combative with the Maintenance Supervisor and attempted to strike him while making delusional statements. There was no documentation to indicate when the resident returned to the facility. The next documented entry in the progress notes was on 4/7/11 at 10:25 a.m., indicating the resident was having delusional | | | |

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| | conversation stating a woman was bothering him. Maintenance staff retrieved the resident from the grocery store across the street from the facility. Half hours checks were to be completed by all facility staff. Again, there was no documentation to indicate if the half hour checks were being completed.<br><br>An entry in the Nursing Progress notes dated 4/18/11 at 2:26 p.m., indicated the resident had increased delusional conversation throughout the 7-3 p.m. shift. Documentation on 4/19/11 at 8:00 p.m., indicated the resident was having difficulty taking his evening meds due to confusion. On 4/21/11 at 1:05 p.m., the resident's conversation remained delusional and his affect remained flat and withdrawn.<br><br>The next documented entry was on 4/25/11 at 9:55 a.m., which indicated the resident was again sent to the Emergency Room for assessment and possible psychiatric hold. The resident had walked away from the facility at 8:00 a.m. and was found approximately 3-4 miles away from the facility. The resident was found by a facility staff member. When the resident was found, he had a change in cognitive status. He was oriented to person only, his speech was delayed and delusional and he had the inability to | | | |

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| | follow simple commands with increased wandering. The resident returned to the facility on 4/25/11 at 5:30 p.m. with extreme confusion.<br><br>The next documented entry in the Nursing Progress notes was on 4/28/11 at 9:07 a.m., which indicated the resident was sent to the Emergency Room for assessment and possible psychiatric evaluation. The resident had been combative towards staff that morning and his peers. He would not keep his clothes on, wearing underwear only. Walking into other resident rooms getting into their beds and showers. Will not speak when spoken to. Unable to assess orientation, resident moves lips without using words. The resident returned to the facility at 1:37 p.m. with no new orders. Documentation indicated his verbal communication was delusional and the resident was placed on half hour checks. All staff was notified as the resident was an increased wandering risk. There was no documentation available to ensure the half hour checks had been completed.<br><br>The next documented entry in the Nursing Progress notes was on 5/2/11 at 8:25 a.m., indicating the resident was sent to the Emergency Room for evaluation due to increased psychosis and combative behavior. The resident attempted to hit | | | |

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| | the Maintenance Supervisor and the Nurse. The resident was unable to follow simple directions. The resident was walking around the facility only wearing a t-shirt. The resident had been going in and out of other resident rooms as well as getting into their beds while naked. He also attempted to hit other residents when they directed him out of their rooms. The next entry in the progress notes was on 5/4/11 at 1:00 p.m. There was no documentation to indicate when the resident returned from the hospital.<br><br>There was no documentation in the resident's record to indicate if anybody had followed up with the long term care facility to see if the resident's bed was available.<br><br>Interview with the Director of Nursing on 6/30/11 at 11:00 a.m., indicated they kept sending the resident out hoping the hospital would admit him. She further indicated there was no documentation related to the ongoing assessment of the resident's behavior and half hour checks. She also indicated no further communication was made related to checking on the availability of the resident's bed at the long term care facility due to the resident seemed better even though he is still on the waiting list. | | | |

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| | An entry in the Nursing Progress notes dated 9/7/10, indicated the resident told staff that he had not had a bowel movement in 4-7 days. The resident received two bisacodyl (laxative) tablets and he was instructed to report to the staff if the medication was effective or not. The next documented entry in the progress notes was on 12/6/10, three months later.<br><br>Interview with the Director of Nursing on 6/30/11 at 11:00 a.m., indicated there was no documentation in the Nursing Progress note to indicate if the prn laxative was effective.<br><br>The resident returned from a physician's visit on 3/15/11 with orders to discontinue the resident's Zocor and Tricor (high cholesterol medications). The resident's Tricor was discontinued on 3/22 and the resident's Zocor was discontinued on 3/30/11.<br><br>Interview with the Director of Nursing on 6/30/11 at 11:00 a.m., indicated that she did not know why there was a delay in discontinuing the resident's medications.<br><br>A Physician's Order dated 4/15/11, indicated the resident was to receive Metoprolol (a blood pressure medication) 50 milligrams (mg) 1/2 tablet twice a day. | | | |

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| | The resident's blood pressure was to be taken before giving the medication.<br><br>Review of the April 2011 Medication Administration Record (MAR), indicated the resident's blood pressure was not taken prior to his 4:00 p.m. dose on 4/6, 4/8, 4/10, and 4/29/11.<br><br>Review of the May 2011 MAR, indicated the resident's blood pressure was not taken prior to his 4:00 p.m. dose on 5/1, 5/6, 5/8, 5/15, 5/18, and 5/28/11. Documentation on the 5/11 MAR, also indicated the medication had not been signed out as given at 8:00 a.m. on 5/29, 5/30, and 5/31/11 and it was also not signed out as given at 4:00 p.m. on 5/28, 5/29, and 5/30/11.<br><br>Interview with the Director of Nursing on 6/30/11 at 11:00 a.m., indicated the resident's blood pressure should have been taken prior to receiving his medication.<br>2. The record for Resident #1 was reviewed on 6/28/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to Schizophrenia and GERD [gastroesophageal reflux disease]. The resident was admitted to the facility on 7/9/08. Review of Physician orders on current 6/11 recap indicated the resident was to have a laboratory draw for a basic chemistry every month. | | | |

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| | Review of the basic chemistry results for the month of March 2011 indicated the resident's sodium level was 117 a critical level. The normal level was 136 to 147. The laboratory had indicated they had called the facility and spoke with LPN #1 (name) on 3/9/11 and informed her of the critical level at 12:40 p.m. The lab results were reported to the facility by the way of the printer/fax on 3/9/11 at 2:56 p.m. On the bottom of the lab page indicated "3/9/11 Dr. (name) notified with the initials of the Director of Nursing."<br><br>Another laboratory result page was noted in the chart dated with collection date of 3/9/11 of the sodium level results. The date it was reported to the facility was 4/13/11. On the bottom of the lab page indicated "4/13/11 Dr. (name) notified with the Director of Nursing's initials.<br><br>Review of Nursing Progress notes indicated there were documented entries dated 1/10/11 and then not again until 3/23/11 at 2:10 p.m. There was no documentation indicating the critical sodium level. There were no assessments of the resident's condition or health status. The next documented entry in Nurse's Notes was on 4/15/11 at 11:25 a.m., which indicated the resident was transferred to the hospital for a critical | | | |

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| | sodium level of 117. On 4/15/11 at 10:45 p.m., Nurse's Notes indicated the resident was being admitted to the hospital with the diagnoses of hyponatremia and hypo-osmolity.<br><br>Interview with the Director of Nursing on 6/29/11 at 9:30 a.m., indicated she was first made aware of the critical lab on 4/13/11. She indicated she just signed the original lab without looking at it and seeing there was a critical lab level. She indicated that when she calls the Physician's office, she usually speaks with the nurse and leaves her the messages and she rarely speaks with the physician himself. She also indicated that LPN #1 indicated to her that she did not take the call from the lab on 3/9/11 at 12:40 p.m. She indicated it might have been possible that the laboratory had called the facility and the front desk informed them LPN #1 was in charge and took the information from the lab and forgot to pass the information onto LPN #1. | | | |
| R0349 | (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows:<br>(1) Complete.<br>(2) Accurately documented.<br>(3) Readily accessible.<br>(4) Systematically organized. | | | |

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| | | A. BUILDING 00<br>B. WING | 06/30/2011 |

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| | Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to diagnoses for allergy medications and antibiotics, lack of documentation related to a fall, lack of documentation related to antibiotic therapy, and lack of follow up documentation related to hospital returns and dialysis therapy for 5 of 7 sampled residents. (Residents #1, #2, #4, #6, and #7)<br><br>Findings include:<br><br>1. The closed record for Resident #7 was reviewed on 6/30/11 at 9:30 a.m. The resident's diagnoses included, but were not limited to, obesity, gastroesophageal reflux disease (GERD), hypertension, psoriasis, and schizophrenia.<br><br>A Physician's order dated 1/6/11, indicated the resident was to receive Benadryl (an anti-histamine) 25 milligrams (mg) 2 tablets by mouth three times a day and Zyrtec (a medication used to treat seasonal allergies) 10 mg by mouth daily. The resident did not have a diagnosis to indicate the use of the medication.<br><br>Interview with the Director of Nursing on 6/30/11 at 11:00 a.m., indicated the | R0349 | A chart audit was completed to ensure that no similar items had occurred. 1, 2, 4, 5 Nursing has been in-serviced on receiving a diagnosis with new medications. Nursing was in-serviced on the importance of correct documentation for the infection control log, resident returns from hospital and any resident falls. Nursing staff responsible. DON to monitor weekly by reviewing physician order sheets, physician notification forms and infection control log. 3 A sheet for documentation for assessment of dialysis site has been developed. Nursing has been in-serviced on its use. Nursing staff responsible. DON to monitor weekly, using the assessment of dialysis site form, on-going. | 07/20/2011 |

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| | resident did not have a diagnosis to support the use of the medications.<br><br>A Physician's order dated 3/31/11, indicated the resident was to receive Clindamycin (an antibiotic) 300 mg by mouth twice a day for 10 days.<br><br>Review of the March and April 2011 Medication Administration Records (MAR's), indicated the resident received the Clindamycin 3/31-4/6/11. There was no documentation in the resident's clinical record to indicate what the antibiotic was being used for.<br><br>Review of the Infection Control log for the months of March and April 2011 on 6/30/11 at 11:30 a.m., indicated the antibiotic and what condition it was being used for was not listed on 3/31/11.<br><br>Documentation in the Nursing Progress notes dated 3/14/11 at 1:20 p.m., indicated the resident was sent to the emergency room for evaluation related to bilateral upper and lower lobe lung congestion. Rales were noted bilaterally and increased shortness of breath was noted. The next documented entry in the Nursing Progress notes was on 3/18/11 at 9:00 p.m., there was no documentation in the progress notes to indicate when the resident returned from the hospital. | | | |

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| | An entry in the Nursing Progress notes dated 4/6/11 at 5:30 p.m., indicated the resident was complaining of head pain and requested to go to the Emergency Room for evaluation. The Resident Transfer Form dated 4/6/11, indicated the resident had fallen and was complaining of pain. There was no documentation related to the fall in the Nursing Progress notes.<br><br>Interview with the Director of Nursing on 6/30/11 at 11:00 a.m., indicated there was no documentation to indicate when the resident returned from the hospital and there was no documentation in the Nursing Progress notes related to the resident's fall on 4/6/11.<br><br>2. The record for Resident #6 was reviewed on 6/29/11 at 1:45 p.m. The resident's diagnoses included, but were not limited to, congestive heart failure and 12/10/10 implantation of ventricular defibrillator.<br><br>An entry in the Nursing Progress notes dated 12/15/10 at 1:30 p.m., indicated the resident had a dressing to the left upper chest that was clean, dry and intact. The dressing was not to be removed unless it was soiled. The resident indicated his shortness of breath had been decreased | | | |

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since his hospital discharge. An entry at 4:30 p.m., indicated the resident's dressing was intact. The next documented entry in the Nursing Progress notes was on 1/1/11.

There was no documentation in the Nursing Progress notes to indicate when the resident returned from the hospital and what the dressing to the left upper chest was for.

Interview with the Director of Nursing on 6/30/11 at 11:00 a.m., indicated that documentation should have been completed when the resident returned from the hospital and documentation should have been completed to indicate what the dressing was for. She further indicated more frequent documentation should have been completed related to the resident's dressing.

3. The record for Resident #4 was reviewed on 6/29/11 at 1:00 p.m. The resident's diagnoses included, but was not limited to, renal failure.

The June 2011 Physician's Order Statement, indicated the resident received dialysis at an outside facility three times a week.

There was an entry in the Nursing Progress notes dated 8/5/10. The next

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| | documented entry was on 3/2/11 at 12:00 p.m., indicating the resident was back from the hospital and the dressing to his left upper extremity was clean dry and intact. There was no documentation to indicate when the resident had gone to the hospital.<br><br>Interview with the Director of Nursing on 6/30/11 at 9:30 a.m., indicated the resident may have been sent to the hospital from dialysis. She indicated she was not sure and documentation should have been completed.<br><br>Review of the Nursing Progress notes for the months of March, April, May and June 2011, indicated there was no documentation related to when the resident left the facility and returned following dialysis treatment and there was no documentation related to an assessment of the resident's dialysis shunt.<br><br>Interview with the Director of Nursing on 6/30/11 at 9:30 a.m., indicated documentation was not being completed when the resident was sent to dialysis and when he returned. She also indicated there was no documentation related to the resident's shunt.<br>4. The record for Resident #2 was revived on 6/28/11 at 10:50 a.m. Review of the Infection Control Log on 6/28/11 at | | | |

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| | 2:00 p.m., indicated the resident received antibiotic therapy in November and December 2010 for bilateral lung congestion. The log did not indicate what the antibiotic was or for how long the resident was receiving the antibiotic.<br><br>Review of Nursing Progress Notes dated 12/1/10 indicated "antibiotic therapy as ordered, no complaints voiced, without signs and symptoms of adverse reactions." The Nursing Progress Note prior to 12/1/10 was dated 8/25/10. There were no Nursing Progress Notes for November 2010.<br><br>Review of Physician Orders dated 11/20/10 indicated Zithromax (an antibiotic) 500 milligrams (mg) daily for seven days. There was no documentation in Nursing Progress Notes of any assessment of the resident's lung sounds, cough, or cold like symptoms.<br><br>Interview with the Director of Nursing on 6/29/11 at 12:00 p.m., indicated there was no documentation of an assessment of the resident's signs or symptoms of cold like symptoms.<br><br>Review of Nursing Progress Notes dated 5/19/11 at 12:20 p.m., indicated nursing staff were sending the resident to the hospital due to having a black eye and it | | | |

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| | was swollen shut. The resident was transferred to the hospital at that time. The next documented Nurse's Notes was on 5/20/11 at 9:34 a.m., which indicated the resident was in the facility with a black eye. There was no documentation on 5/19/11 as to when the resident returned from the hospital.<br><br>Interview with the Director of Nursing on 6/29/11 at 12:30 p.m., indicated the resident returned to the facility on 5/19/11 and was only gone a couple of hours at the hospital. The Director of Nursing indicated at the time, there was no documentation in Nurse's Notes regarding his return to the facility.<br><br>5. The record for Resident #1 was reviewed on 6/28/11 at 10:15 a.m. The resident's diagnoses included, but were not limited to GERD and schizophrenia. Review of the resident's medications indicated he was receiving Benadryl (an antihistamine) 25 mg two tablets at night time since 9/21/10 and Claritan (an allergy medication) 10 mg daily since 7/10/08.<br><br>Further review of the resident's record indicated there was no diagnoses for both of those medications. There was no documentation the resident was having problems with seasonal allergies or | | | |

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| | having problems with sleep.<br><br>Interview with the Director of Nursing on 6/29/11 at 12:45 p.m., indicated the resident was taking the Benadryl for sleep and the Claritin for allergies. The Director of Nursing further indicated at the time, there was no diagnoses for either one of those medications. | | | |
| R0410 | (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.<br>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>Based on record review and interview, the facility failed to ensure an annual tuberculin skin test was completed for 1 of 7 sampled residents. (Resident #4)<br><br>Findings include: | R0410 | A chart audit was completed to ensure that no similar items had occurred.Test was given to resident.When a resident is not in the facility when the doctor administers the yearly TB skin test, the facility will make | 07/20/2011 |

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| | The record for Resident #4 was reviewed on 6/29/11 at 1:00 p.m. Review of the annual physical sheet, indicated the resident's last tuberculin (TB) skin test was in May 2010. There was no documentation to indicate the resident had received a tuberculin skin test in May 2011.<br><br>Interview with the Director of Nursing on 6/30/11 at 10:00 a.m., indicated the physician now administers the TB skin tests and the day the physician was in the facility in May, the resident was out to dialysis and he got missed. | | arrangements to transport the resident to the doctors office for the test.Nursing staff responsible.DON to monitor monthly during chart audits. on-going. | |